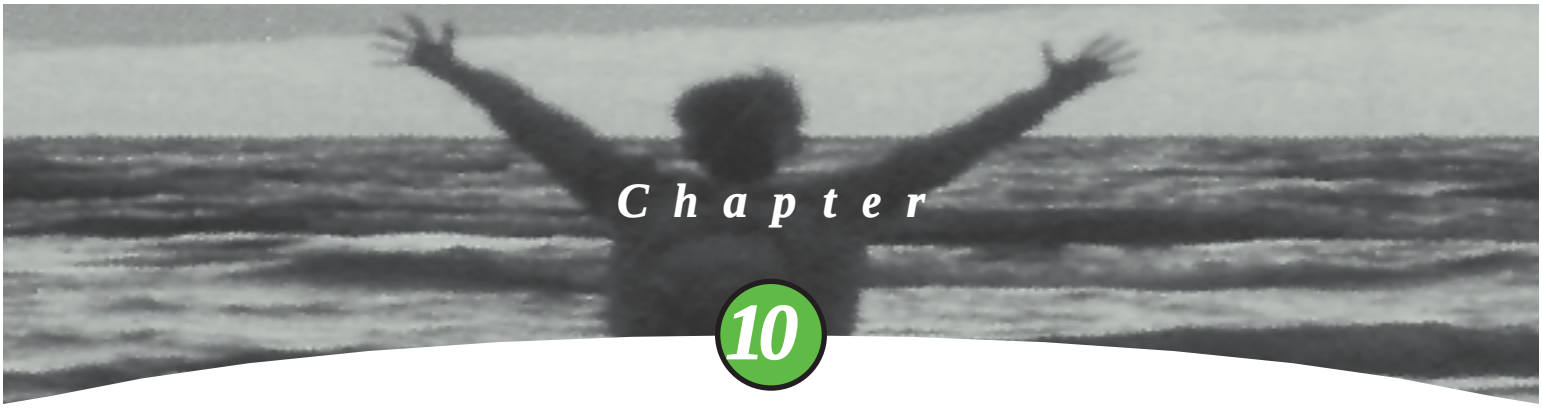

Chapter

10

Culture

Overview

The concept of culture refers to a shared identity based on such factors as common language, shared values and attitudes, and similarities in ideology. In terms of health, some cultural groups face additional risks because of dominant cultural values that contribute to conditions such as marginalization, stigmatization, loss or devaluation of language and culture, lackof access to culturally appropriate health care and services, and lack of recognition of skills and training.

Racism and discrimination have direct impacts on health, as well as indirect impacts mediated through various forms of social, political and economic inequity. For example, the factors that contribute to the major health disparities between First Nations, Inuit and Métis communities and other communities (including education, income, culture, and social and physical environment) are rooted in a long history of prejudice and racism.

Relationship to Healthy Child Development

Minority groups often experience "acculturative stress."

New immigrants and refugees, as well as Aboriginal people and other ethnic group members are likely to experience stress from a variety of sources — including their economic circumstances, social and personal isolation, negative attitudes, and threatened or actual violence (Berry, 1980). This "acculturative stress" can have significant health impacts, both physical and mental. For example, Aboriginal people in Canada often experience stress when they move from an area of relative isolation or a smaller community to a large urban centre. This stress may result in problems of alcoholism, family disruption and physical illness (Masi, 1989a, p. 72).

One significant source of stress among members of immigrant groups is the conflict between adults and children. Immigrant children tend to integrate more quickly into the dominant culture (Baptiste, 1990; Kim, 1980), often learning the language and cultural mores before their parents. As a result, children become the family's translators and cultural interpreters, with a consequent reversal of roles and destabilization of normal lines of community and authority in the family (Baptiste, 1993).

Minority cultural groups may also feel conflicting desires and expectations for their children — on the one hand, fearing that their children will acquire undesirable aspects of the new culture and, on the other, wanting them to obtain the characteristics that will equip them for success (Wakil, Siddique and Wakil, 1981; Xenocostas, 1991; Markowitz, 1994). The potential for conflict is particularly high during adolescence, when issues of separation, individuation and identity rise to the surface (Baptiste, 1993). It is important to note that while families play an important role in passing along culture, the importance of the family has declined relative to the impact of other sources of cultural influence, such as the marketplace and schools (Erickson, 1991, p. 1).

Aboriginal people in Canada often experience stress when they move from an area of relative isolation or a smaller community to a large urban centre.

Migration can affect physical health.

There is some evidence that migration poses a threat to physical health because of dietary changes and exposure to local pathogens against which migrants have no immunity (Beiser et al., 1995, p. 68).

Refugees face unique stresses.

There is some evidence that voluntary migrants (e.g. immigrants) experience less stress than those who expose themselves to cultural change involuntarily (e.g. refugees and Aboriginal people) (Berry et al., 1987). Poverty, combined with uncertainty about the outcome of their refugee claim and negative attitudes in the host country, can create enormous stress for refugees. As well, refugee children are likely to have experienced violence in their homelands and may be at high risk for post-traumatic stress disorder (Beiser et al., 1995, p. 68).

The context of resettlement plays a mitigating role.

While the experience of migration and resettlement itself may result in significant stress for families, there are a number of mitigating factors that determine whether or not immigration is necessarily followed by maladaptation. These factors include selection policies, pre-migration experiences and the welcome accorded by the host country (Beiser et al., 1995, p. 67).

Stress, personal strengths and social resources interact in complex ways to determine health risks for minority cultural groups. Factors such as maternal loss, depressed mothers and general family instability contribute increased vulnerability among refugee and immigrant children. These factors also contribute to lower scholastic achievement levels and a higher delinquency rate (Rumbaut and Ima, 1988, as cited in Beiser et al., 1995).

Children who are separated from family members during the early years of resettlement are at an increased risk for negative mental health consequences, particularly if they are placed with a family of a different ethnic origin (Porte and Torney-Purta, 1987).

Racism and discrimination contribute to stress.

Many minority groups in Canada report experiencing racism and discrimination. For example, half of Indo-Canadian men and women living in South Vancouver reported experiencing some form of racial hostility, ranging from verbal abuse and physical harm to work force discrimination (Nodwell and Guppy, 1992). In the 1980s, testimonies of racial minorities before the House of Commons Special Committee on Participation of Visible Minorities in Canada revealed many instances of differential treatment. One study of the Chinese community in Toronto found that perceived discrimination correlated with various psychological symptoms, such as nervousness, sleep problems, headaches, mood and degree of worry (Dion, Dion and Pak, 1992).

Intercultural Adoptees

One study found that intercountry adoptees are as well-adjusted as children in the population as a whole. These children are well integrated, have high self-esteem and positive peer relations. The only area of concern is with respect to ethnic and racial identity (Westhues and Cohen, 1994). Furthermore, there is evidence that children of parents who maintain their ethnic pride and cultural identity perform better than children whose parents assimilate fully (Rumbaut and Ima, 1988, as cited in Beiser et al., 1995). Cultural kinship — identifying with the language and history, religious and ceremonial rituals, and codes of behaviour of a culture — contributes to children's sense of identity, security and self-esteem (Haka-Ikse, 1988, p. 1113).

Cultural differences affect life changes.

The life changes (e.g. education, occupational status and employment income) for immigrants vary according to their country of origin. For example, European immigrants fare better in the Canadian labour market than their Black and Asian counterparts (Reitz and Breton, 1994, pp. 112–114).

Cultural background, including ethnicity, can have an effect on academic success (Farkas et al., 1990, p. 3). Despite some emphasis on multicultural education, Canadian schools generally reproduce the cultures and values of the dominant group (Hébert, 1992; Shamai, 1992). Language and communication problems cause a disproportionate number of children from certain cultural groups to be placed in special and vocational education classes (Toronto Board of Education Consultative Committee on the Education of Black Students in Toronto Schools, 1987). The result has been that the future education and careers of these children are seriously limited (Masi, 1989a, p. 71).

Another study found that immigrant children whose mother tongue is neither English nor French initially obtain lower marks in English compared with Canadian-born children; however, they eventually catch up in their ability to speak French or English, as well as in many other areas of school performance (Samuel and Verma, 1992, pp. 55–56).

Cultural ties also help to maintain occupational segregation (Reitz, 1990). Lack of recognition of diplomas and training received by immigrants in their homeland decreases their access to work, resulting in occupational ghettoizing and low socio-economic status (Maritime Centre of Excellence for Women's Health, 1997).

Culturally sensitive health and social services are important.

There is considerable evidence that physicians' awareness of cultural issues can positively affect the patient–physician relationship and contribute to patient compliance and positive health outcomes. For example, an evaluation of Aboriginal health services suggested that their effectiveness was often compromised by the cultural differences between those giving and those receiving the services (Gibbons, 1992). Family physicians — often the first

Female Genital Mutilation

Generally performed prior to puberty, female genital mutilation (FGM) involves the removal of part or all of the female genitalia and, in the most severe cases, the clasping together of the labia. FGM is based on traditional practice rather than religion, and is employed in some cultures as a way of controlling women's attitudes towards sex, their sexuality, and of reinforcing the belief that it is necessary to ensure their virginity and marriageability. FGM is most commonly practised in Africa but is also experienced by women in parts of Asia and some countries in the Middle East. Some women and girls who emigrate to Canada were subjected to FGM prior to their arrival. In Canada, FGM is forbidden under the general provisions of the Criminal Code, and recent amendments to the Criminal Code have made it illegal to transport a child out of Canada with the intention of performing FGM.

point of contact with the Canadian health system — are under particular pressure to become familiar with the special needs of clients from different cultures (Hamilton, 1996, p. 585).

Other factors play a role, including traditional beliefs about the causes of illness, attitudes towards caregivers and family values about care. Some cultural groups routinely involve members of the extended family in providing care. For example, people from developing countries often have a health-care network that includes parents, relatives and non-relatives as health-care provider (Masi, 1989b, p. 252). Moreover, language difficulties can cause misunderstandings by both physicians and immigrants, affecting diagnosis and treatment. While large urban areas may have access to language interpretation services, the lack of such services in smaller communities is a concern (Masi, 1989a, p. 71).

The issue of wife abuse must be addressed in a sensitive manner. Generally, immigrant women and those from some ethnic groups who are battered have little recourse. In some cases, community members may be more likely to support the husband. Often, there are few outside resources available to these battered women because of language or cultural barriers (Masi, 1989b, p. 253). As seen in Chapter 4, witnessing spousal violence appears to have the strongest influence on young people's risk factors, including substance abuse and criminal behaviour (Marion and Wilson, 1995, pp. 28–29).

Conditions and Trends

The conditions and trends listed here are not intended to be comprehensive, but rather to provide examples of how cultural differences exist in some key areas related to health.

Language and Ethnicity

- In the 1996 Census, 28% of the population identified themselves as having a background other than British Isles, French or Canadian (Statistics Canada, 1998a).

- In 1996, Canada's visible minority population totalled 3,197,480, representing 11.2% of the total population (28,528,125) (Statistics Canada, 1998b). See **Exhibit 10.1**.

- In 1996, Statistics Canada reported that about 16% of Canadians had a mother tongue other than English or French (Statistics Canada, 1998b).

- About one quarter of all migrant children younger than age 12 enter Canada as refugees (Beiser et al., 1995, p. 67).

- Traditionally, the sources of the majority of Canadian immigrants have been Europe and the United States. More recently, Asia, Africa, the Middle East and Latin America account for about three quarters of Canada's new immigrant population (Beiser et al., 1995, p. 68).

10.1 Distribution of visible minority population[a] by age, Canada, 1996

	Total	0–14	15–24	25–44	45–64	65–74	75+
	Number						
Total population	**28,528,125**	**5,899,200**	**3,849,025**	**9,324,340**	**6,175,785**	**2,024,180**	**1,255,590**
Total visible minority population[b]	3,197,480	778,340	521,060	1,125,730	581,275	129,415	61,655
Black	573,860	170,870	96,895	186,995	94,520	16,025	8,555
South Asian	670,590	168,585	107,465	230,245	127,355	26,425	10,505
Chinese	860,150	171,110	135,580	299,815	177,980	50,680	24,990
Korean	64,840	12,115	15,525	19,475	14,610	1,765	1,340
Japanese	88,135	12,545	11,830	20,850	14,670	5,280	2,965
Southeast Asian	172,195	49,295	28,380	68,210	20,195	4,895	1,785
Filipino	234,195	50,985	33,995	90,100	45,370	8,845	4,900
Arab/West Asian	244,665	60,850	37,040	95,005	39,995	8,185	3,630
Latin American	176,975	46,530	31,575	68,500	25,190	3,670	1,500
Visible minority[c]	69,745	15,065	11,015	27,690	12,995	2,160	915
Multiple visible minority[d]	61,575	20,385	11,755	18,945	8,425	1,480	575

a. The *Employment Equity Act* defines the visible minority population as persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.
b. The visible minority groups are based on categories used to define the visible minority population under the Regulations to the *Employment Equity Act*.
c. Not included elsewhere. Includes Pacific Islander group or another write-in response likely to be a visible minority (e.g. West Indian, South American).
d. Includes respondents who reported more than one visible minority group.

Source: Adapted from the Statistics Canada Web site: www.statcan.ca

Injuries

- Injury-related mortality rates among young Status Indians (0 to 19 years old) are three times the national average (Health Canada, 1997, p. 55).

- Drowning rates are about eight times higher among First Nations and Inuit children and youth aged 0 to 19 years (Health Canada, 1997, p. 185).

Suicide

Children and youth aged 0 to 19 in Aboriginal reserve communities have a suicide rate almost five times that of children and youth in the general population (Health Canada, 1997, p. 55).

Education

The majority of immigrant children aged 4 to 17 who came to Canada between 1981 and 1988 did not speak either official language (Samuel and Verma, 1992, pp. 53–54).

Culture and Other Determinants

Education and Employment

Culture affects a person's education and occupation, as well as the education and occupation of the person's spouse; this, in turn, has considerable consequences for income, knowledge of support structures, access to informal support in social networks, and personal coping skills (Erickson, 1991, p. 4).

Natural and Built Environments

Aboriginal children face a number of risks related to the natural and built environment. For example, Aboriginal children have an injury rate almost six times that of other Canadian infants (Health Canada, 1997, p. 55). They are also at greater risk of exposure to contaminants because of poor housing conditions, contaminated food sources, water supply and sanitation, and indoor and outdoor environmental contaminants (Postl, MacDonald and Moffat, 1994; Young, Bruce and Elias, 1991).

Personal Health Practices

There is evidence that culture affects personal health practices. For example, the prevalence of smoking is high among Inuit and Francophone women and low among most immigrant women (Maritime Centre of Excellence for Women's Health, 1997). Alcoholism has been noted as more prevalent among the Irish than the Jewish (Henderson and Primeaux, 1981, p. xix), and is virtually unheard of as a social or medical problem in Chinese society (Lin T.-y., 1983, p. 864). There are strong indicators that these differences are due to cultural factors, such as the degree of tolerance of alcohol use in a given community (Masi, 1989b, p. 253).

The majority of immigrant children aged 4 to 17 who came to Canada between 1981 and 1988 did not speak either official language.

Individual Capacity and Coping Skills

The incidence of suicide is higher among Aboriginal youth than among other Canadian young people. One recent study reported a suicide rate for Status Indians (aged 0 to 19) almost five times higher than the national average (Health Canada, 1997, p. 55).

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